

HEALTH HISTORY RECORD

Michigan Department of Human Services

Dear Authorized Person:

The following information is request so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. (Use back of form if additional space is required.) "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)		First		Middle	Sex	Date of Birth
Address (Number and Street)		City			Zip	Telephone (Home)
Authorized Person's Name (Last)		First		Middle	Telephone (Work)	
Address (Number and Street)		City			Zip	Telephone (Emergency)
Is the camper having any of the problems listed below?		Yes	No			Yes No
1. Hay fever, asthma, or wheezing		<input type="checkbox"/>	<input type="checkbox"/>	7. Trouble with passing urine or bowel movements		<input type="checkbox"/> <input type="checkbox"/>
2. Eczema or frequent skin rashes		<input type="checkbox"/>	<input type="checkbox"/>	8. Shortness of breath		<input type="checkbox"/> <input type="checkbox"/>
3. Convulsions/seizures		<input type="checkbox"/>	<input type="checkbox"/>	9. Speech problems		<input type="checkbox"/> <input type="checkbox"/>
4. Heart Trouble		<input type="checkbox"/>	<input type="checkbox"/>	10. Menstrual Problems		<input type="checkbox"/> <input type="checkbox"/>
5. Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	11. Dental problems		<input type="checkbox"/> <input type="checkbox"/>
6. Frequent colds, sore, throats, ear aches (4 or more per Year)		<input type="checkbox"/>	<input type="checkbox"/>	12. Other		<input type="checkbox"/> <input type="checkbox"/>

Please explain any problem areas identified above including any current infectious diseases:

If female has she been told about menstruation (answer if appropriate)

☐ Yes ☐ No

Has she menstruated (answer if appropriate)

☐ Yes ☐ No

Operations or Injuries

Explain Any Special Health, Behavioral or Emotional Consideration(s)

Medication Needed or Used (Including Psychiatric)

Currently Being Given

Kind	Frequency	Dosage	Yes	No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin or other drugs), Bedwetting, Fainting, Sleep Walking, etc.

IMMUNIZATION		Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping cough)	Measles	Rubella	Hepatitis B	Other
	Date Initial Immunization Completed									
	Date of Most Recent Booster									

Should the camper's activity be restricted because of any physical limitation or illness?

☐ No ☐ Yes

If yes, explain degree of restriction:

I certify that this information is true to the best of my knowledge.

Authorized Person's Signature

Date

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.